DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 4

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JANUARY 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. 8440.120

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 12,000
b. FFY 2002 $ 17,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-B, PAGES 6 AND 7
SUPPLEMENT TO ATTACHMENT 3.1-A AND 3.1-B,
PAGES 3.2, 3.3 AND 3.4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-B, PAGES 6 AND 7
SUPPLEMENT TO ATTACHMENT 3.1-A AND 3.1-B,
PAGES 3.2, 3.3 AND 3.4

10. SUBJECT OF AMENDMENT:
PRESCRIBED DRUGS

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Susan M Chandler

13. TYPED NAME:
Susan M. Chandler

14. TITLE:
Director

15. DATE SUBMITTED:
3/27/01

16. RETURN TO:
STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
P.O. BOX 339
HONOLULU, HAWAII 96809-0339

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 28, 2001

18. DATE APPROVED:
7/20/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

12a. Prescribed drugs must be listed in the Hawaii Medicaid Drug Formulary: all other prescribed drugs require prior authorization.

(1) Those drug products produced by manufacturers who have entered into and comply with an agreement under Section 1927(a) of the Act are payable by being listed in the Hawaii Medicaid Drug Formulary or by prior authorization, except those drugs:

(a) Used for cosmetic purposes or hair growth;

(b) With associated tests or monitoring purchased exclusively from the manufacturer or designee as a condition of sale;

(c) Which are classed as "less than effective" as described in Section 107(c)(3) of the Drug Amendments of 1962 or are identical, similar or related; and

(d) Used to promote fertility.

(2) The following drugs or classes of drugs, produced by manufacturers complying with Section 1927(a) of the Act, or their medical uses will be selectively covered as decided by the Advisory Medicaid Formulary Committee (the responsibilities for which have been delegated to the State Drug Use Review Board);

(a) Agents used for the symptomatic relief of cough and colds.

(b) Vitamins and minerals products except prenatal and fluoride preparations;

(c) Non-prescription drugs;

(d) Barbiturates;

(e) Benzodiazepines; and

(f) Agents used for anorexia or weight gain.

(3) The State will not enter into any separate or any rebate agreements without amendment to the State Plan nor without reporting any rebates received from any separate agreements. Any Possible future rebate agreement will be submitted to the Health Care Financing Administration (HCFA) for approval implementation.

(4) Prior authorization imposed on any covered outpatient drug will meet the following conditions:

(a) Prior authorization requests will be responded to within 24 hours of receipt by telephone or other telecommunication; and

(b) In an emergency, a seventy-two hour supply of the drug desired by the prescribing physician will be allowed (an emergency is defined as a situation that exists when the withholding of medication chosen by the prescribing physician will cause the patient's medical condition to worsen

and the person designated to approve prior authorization is not available for approval by telephone or other means).

(5) The maximum quantity of any medication to be paid equals the larger of a one month supply or one hundred units.

(6) In compliance with Section 1927(b)(2) of the Social Security Act, the fiscal agent is engaged to report to each manufacturer not later than sixty days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter and shall promptly transmit a copy of such report to the Secretary as instructed by HCFA.

12b. Partial dentures limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars. Temporary dentures allowed only when teeth have been extracted recently with prior authorization and subject to maximums or prosthetics.

Only one prosthetic appliances in any five year period is allowed for a maximum of one for each type, partial and full dentures, per arch per recipient; lifetime. This is allowed when present or previous dentures cannot be repaired or adjusted.

12c. Prosthetic devices require prior authorization when the cost of purchase, repair or manufacture exceeds $50.00.

3. Medicare's upper limit of payment.

The payment to an emergency room physician for the screening and assessment of a patient who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straightforward medical decision making.

(q) The upper limits on payments for all noninstitutional items and services shall be established by the department in accordance with section 346-59, HRS, and other applicable state statutes.

4. PAYMENT FOR CERTAIN OTHER NON-INSTITUTIONAL ITEMS AND SERVICES:

a. Payment for prescribed drugs:

1. For single source drugs, shall not exceed the lower of:

A. The billed charged;

B. The provider's usual and customary charge to the general public; or

C. The estimated acquisition cost (EAC) or the average wholesale price (AWP) when the AWP is the average selling price, plus a reasonable dispensing fee.

2. For multiple source drugs, shall not exceed the lower of:

A. The billed charges;

B. The provider's usual and customary charge to the general public;

C. The estimated acquisition cost (EAC) or the average wholesale price (AWP) when the AWP is the average selling price, plus a reasonable dispensing fee;

D. The Federal Upper Limit (FUL) price plus a reasonable dispensing fee; or

E. The State Maximum Allowable Cost (MAC) plus a reasonable dispensing fee;

3. Over-The-Counter (OTC) drugs shall not exceed the lower of:

   A. The billed charges;

   B. The provider's usual and customary charge to the general public including any sale item which may be available on the day of service;

   C. The allowance set by the program (State maximum allowable costs);

   D. The estimated acquisition cost (EAC) or the average wholesale (AWP) when the AWP is the average selling price, plus a reasonable dispensing fee; or

   E. The Federal Upper Limit (FUL) price plus a reasonable dispensing fee;

   Under no circumstances shall the program pay more than the general public for the same prescription or item.

4. Payments for medical supplies shall be made as described in section 3 (l) above.

5. The Federal Upper Limit (FUL) price does not apply if a physician:

   A. Certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient. A checkoff box on a form is not acceptable by a notation of "brand medically necessary" or do not substitute" is allowable.

   B. Obtains medical authorization for medical necessity from the state medical assistance program for specific brands of medication designated by the program.

   In such cases, the payment shall not exceed the lower of:

   A. The billed charge;